Benefit Choice Period: May 1 – May 31, 2017

The Benefit Choice Period will be **May 1 through May 31, 2017** for eligible members. Members are employees (full-time employees, part-time employees working 50% or greater and employees on leave of absence), COBRA participants, and annuitants and survivors not enrolled in the Medicare Advantage TRAIL Program. **Elections will be effective July 1, 2017.**

For more information on your benefit options, go to MyBenefits.illinois.gov.

NEW ONLINE ENROLLMENT PLATFORM

Making benefit elections is simple through the MyBenefits website. Follow these steps to register.

1. Log on to **MyBenefits.illinois.gov.**
2. In the top right corner of the home page, click *Login.*
3. Enter your login ID and password. If you are logging in for the first time, click *Register* in the bottom right corner of the login box and follow the prompts. You will need to provide your name as printed on the Benefit Choice Period materials mailed to your home.
4. After logging in and landing on the welcome page, explore your benefit options by clicking on the benefit tiles or utilizing the decision support tool.
5. After exploring your benefit options and determining which benefits you would like to elect, follow the prompts on the welcome page.

Consider Going Paperless! Provide your email address on the MyBenefits website to receive quicker responses and notifications through electronic communications.

Contact MyBenefits Marketplace Service Center at (844) 251-1777 or (844) 251-1778 (TDD/TTY) with questions about navigating the MyBenefits website or how to elect benefits. Representatives are available Monday – Friday, 7:30 a.m. – 7:00 p.m. Central Time during the Benefit Choice Period, and Monday – Friday, 8:00 a.m. – 6:00 p.m. Central Time throughout the rest of the year.

What is Changing

Starting this year, you will have more ownership over your benefit elections. Take advantage of this opportunity to understand your benefit options and make an informed decision.

New Online Enrollment Platform MyBenefits.illinois.gov

This year, for the first time, participation is easier than ever through the MyBenefits website.

New Health Plan Administrator

The Quality Care Health Plan (QCHP) previously administered by Cigna will be transitioned to Aetna.

Plan Administrator Name Change

Aetna will also administer the Aetna HMO, formerly Coventry Health Care HMO, and the Aetna OAP, formerly Coventry Health Care OAP.

Medical Care Assistance Plan (MCAP)

The MCAP maximum contribution amount will be $2,600 for the 2018 plan year with a $500 maximum rollover. Employees must re-enroll in MCAP for the new plan year in order to qualify for the rollover.

What is Not Changing

Premiums

Employee and dependent premiums will remain the same for this Benefit Choice Period.

Managed Care Plan Administrators

Plan administrators will remain the same for all managed care plans (OAP and HMO plans).

- Aetna HMO (formerly Coventry Health Care HMO)
- Aetna OAP (formerly Coventry Health Care OAP)
- BlueAdvantage HMO
- Health Alliance HMO
- HealthLink OAP
- HMO Illinois

Note that other plan administrators will remain the same for other benefits, including dental, vision, behavioral health, prescription drugs, flexible spending accounts, and life insurance.

Health Plan Options

There will be no changes to your health plan options this Benefit Choice Period. If you wish to keep your coverage, no action is needed. If you wish to change your plan or carrier, go online at MyBenefits.illinois.gov.

DISCLAIMER

The health plan options outlined in this Benefit Choice book are subject to change pending final resolution of the collective bargaining process and litigation arising from that process. If that process results in significant changes in plan designs, benefit levels, or premiums, a second Benefit Choice Period may be held for any members impacted by such changes. If a second Benefit Choice Period is held, members will have the opportunity to change plans at that time with updated information. For the latest information, please continue to visit MyBenefits.illinois.gov.

Members may make the following changes during the Benefit Choice Period on the MyBenefits website:

It is each member's responsibility to know their plan benefits in order to make an informed decision regarding coverage elections.

- Change health plans.
- Add or drop dental coverage.
- Add or drop dependent coverage.
- Add, drop, increase, or decrease Member Optional Life insurance coverage; or add or drop Child Life, Spouse Life, and/or AD&D insurance coverage.
- Elect to opt out (applies only to full-time employees, including those on a leave of absence, annuitants, and survivors). All members electing to opt out must provide proof of other comprehensive health coverage. Proof of other coverage must be from a source other than CMS.
- Elect to waive health, dental, vision, and prescription coverage (part-time employees 50% or greater, annuitants, and survivors).
- Re-enroll in the Program if you previously opted out of or waived coverage.
- Re-enroll in the Program if coverage is currently terminated due to nonpayment of a premium while on leave of absence (employees only – subject to eligibility criteria). Any outstanding premiums must be paid before coverage will be reinstated. Contact the Premium Collection Unit to discuss your options at (217) 558-4783.
- Enroll in MCAP and/or DCAP. **Employees must enroll each year; previous enrollment in the program does not continue into the new plan year.**

Go to the MyBenefits website if you are uncertain whether or not a life-changing event needs to be reported.

DOCUMENTATION REQUIREMENTS

- Documentation, including the SSN, is required when adding dependent coverage.
- An approved statement of health is required to add or increase Member Optional Life coverage or to add Spouse Life or Child Life coverage.
- If opting out, proof of other comprehensive health coverage provided by an entity other than the Department of Central Management Services is required.
- Documentation must be submitted to the MyBenefits website or MyBenefits Marketplace Service Center at the following address no later than June 5. Failure to provide adequate documentation by this deadline may result in dependents not being added to your plan.

MyBenefits Service Center, 134 N. LaSalle Street, Suite 2200, Chicago, IL 60602

State of Illinois

Medicare COB Unit
PO Box 19208
Springfield, IL
62794-9208
Fax: (217) 557-3973

Total Retiree Advantage Illinois (TRAIL)

Medicare Advantage Program

Members who are enrolled in Medicare Parts A and B and meet all of the criteria for enrollment in the Medicare Advantage Program will be notified by mail of the TRAIL Open Enrollment Period by the Department of Central Management Services. Information regarding enrollment will be mailed out this fall to all who meet the criteria. These members will be required to choose a Medicare Advantage plan or opt out of all State coverage (which includes health, behavioral health, prescription drug, dental, and vision coverage) in the fall with an effective date of January 1, 2018. For more information regarding the Medicare Advantage 'TRAIL' Program, go to MyBenefits.illinois.gov.

Your Health Plan Options

The State of Illinois offers comprehensive health plan options, all of which include prescription drug, behavioral health, and vision coverage.

Consider your health needs, as you select between QCHP, HMO, and OAP plans.

- **Quality Care Health Plan (QCHP)** members can choose any physician or hospital for medical services; however, members receive enhanced benefits, resulting in lower out-of-pocket costs, when receiving services from a QCHP in-network provider. QCHP has a nationwide network and includes CVS/caremark for prescription drug benefits and Magellan Behavioral Health for behavioral health services.
- **Health Maintenance Organizations (HMO)** members are required to stay within the health plan provider network. No out-of-network services are available. Members will need to select a primary care physician (PCP) from a network of participating providers. The PCP will direct all healthcare services and make referrals to specialists and hospitalization.
- **Open Access Plans (OAP)** members will have three tiers of providers from which to choose to obtain services. The benefit level is determined by the tier in which the healthcare provider is contracted.
  - Tier I offers a managed care network which provides enhanced benefits and operates like an HMO.
  - Tier II offers an expanded network of providers and is a hybrid plan operating like an HMO and PPO.
  - Tier III covers all providers which are not in the managed care networks of Tiers I or II (i.e., out-of-network providers). Using Tier III can offer members flexibility in selecting healthcare providers, but involves higher out-of-pocket costs. Furthermore, members who use out-of-network providers will be responsible for any amount that is over and above the charges allowed by the plan for services (i.e., allowable charges), which could result in substantial out-of-pocket costs.

  Members enrolled in an OAP can mix and match providers and tiers.

Go to the new MyBenefits website at MyBenefits.illinois.gov for additional information, resources, and forms. Additional health plan or prescription drug information can be viewed and compared online. Click the Health Plan tile on the home page.

HMO Administrators
- BlueAdvantage HMO
- Aetna HMO (formerly Coventry Health Care HMO)
- Health Alliance HMO
- HMO Illinois

OAP Administrators
- Aetna OAP (formerly Coventry Health Care OAP)
- HealthLink OAP
- *Prescription Drug Coverage through CVS/caremark*

QCHP Administrator
- Quality Care Health Plan (Aetna)
- *Prescription Drug Coverage through CVS/caremark*
- *Behavioral Health Services through Magellan Behavioral Health*

Benefits are outlined in the plan's summary plan document (SPD). It is the member's responsibility to know and follow the specific requirements of the plan. Contact the plan administrator for a copy of the SPD.

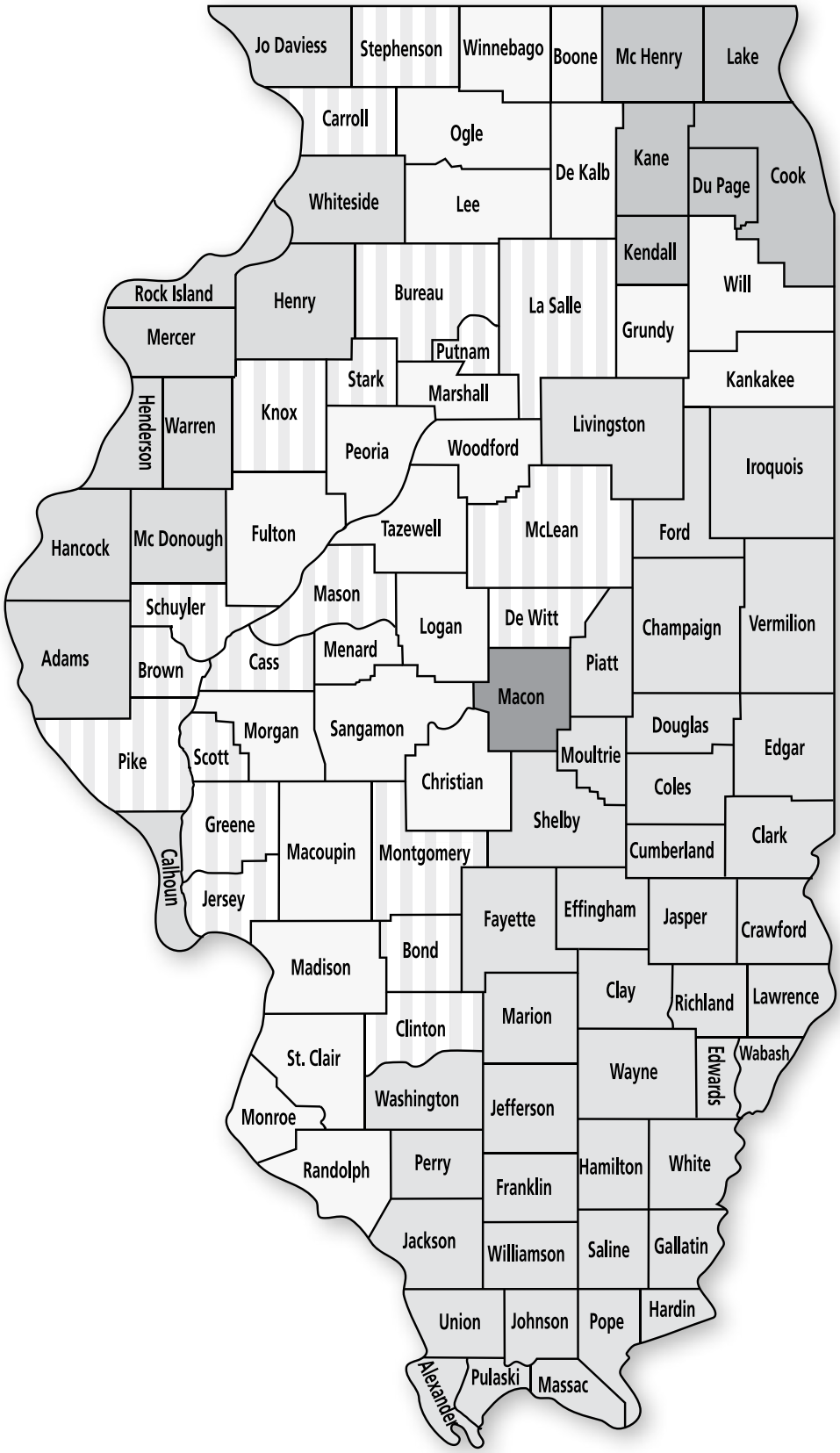
State Employees Group Insurance Program Medicare Requirements

Each member and dependent must contact the Social Security Administration (SSA) and apply for Medicare benefits upon turning the age of 65. If the SSA determines that the member and/or dependent is eligible for Medicare Part A at a premium-free rate, the member and/or dependent is required by the State to enroll in Medicare Part A. Retirees and survivors, as well as employees without current employment status (on a disability leave of absence), must also enroll in Medicare Part B, if eligible. Once enrolled in Medicare, the member and/or dependent is required to send a front side copy of the Medicare identification card to the State of Illinois Medicare COB Unit. Refer to page 2 for the Medicare COB Unit contact Information.

If the SSA determines that a member is not eligible for premium-free Medicare Part A based on his/her own work history or the work history of a spouse at least 62 years of age (when applicable), the member must request a written statement of the Medicare ineligibility from the SSA. Upon receipt, the written statement must be forwarded to the State of Illinois Medicare COB Unit to avoid a financial penalty. Members who are ineligible for premium-free Medicare Part A benefits, as determined by the SSA, are not required to enroll into Medicare.

What is Available in Your Area in FY18

Review the map and charts in this flyer to compare plans and determine which plan is best for you.



Health Alliance HMO
Aetna HMO (formerly Coventry HMO)
HMO Illinois
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Striped areas represent counties in which HMO Illinois or BlueAdvantage HMO do not have provider coverage; members in these counties may have access to HMO Illinois or BlueAdvantage HMO providers in a neighboring county.

Monthly Contributions

The State shares the cost of health coverage with you. While the State covers the majority of the cost, you must make monthly contributions determined by your annual salary. The following chart outlines contribution rates for full-time members. Note that part-time members are required to pay a percentage of the State's portion of the contribution in addition to their own.

Employee Annual Salary	Employee Monthly Health Plan Contribution Amounts	
$30,200 & below	Managed Care: $68	Quality Care: $93
$30,201 - $45,600	Managed Care: $86	Quality Care: $111
$45,601 - $60,700	Managed Care: $103	Quality Care: $127
$60,701 - $75,900	Managed Care: $119	Quality Care: $144
$75,901 - $100,000	Managed Care: $137	Quality Care: $162
$100,001 & above	Managed Care: $186	Quality Care: $211

Members who retire, accept a salary reduction, or return to State employment at a different salary may have their monthly contribution adjusted based upon the new salary. This applies to members who return to work after having a 10-day or greater break in State service after terminating employment. This does not apply to members who have a break in coverage due to a leave of absence.

In addition to monthly contributions for their own health coverage, members must make additional contributions for dependents they cover. Dependents must be enrolled in the same plan as the member. The Medicare dependent contribution applies only if Medicare is primary for both Parts A and B.

Dependent Monthly Health Plan Contributions				
Health Plan Name and Code	**1 Dependent**	**2+ Dependents**	**1 Medicare A and B Primary Dependent**	**2+ Medicare A and B Primary Dependents**
Aetna HMO (formerly Coventry Health Care HMO)	$111	$156	$88	$130
Aetna OAP (formerly Coventry Health Care OAP)	$111	$156	$88	$130
BlueAdvantage HMO	$96	$132	$75	$110
Health Alliance HMO	$113	$159	$89	$133
HealthLink OAP	$126	$179	$102	$149
HMO Illinois	$100	$139	$79	$116
Quality Care Health Plan (Aetna)	$249	$287	$142	$203

Retiree, Annuitant, and Survivor Monthly Health Plan Contributions	
20 years or more of creditable service	$0
Less than 20 years of creditable service and, • SERS/SURS annuitant/survivor on or after 1/1/98, • TRS annuitant/survivor on or after 7/1/99	Five percent (5%) of the costs of the basic program of group health benefits for each year of service less than 20 years.

Call the appropriate retirement system for applicable premiums.

SERS: (217) 785-7444
SURS: (800) 275-7877
TRS: (800) 877-7896

DISCLAIMER

Retiree, annuitant, and survivor contributions for all health plan options will be in accordance with the levels set forth above in FY18. For future years, the State reserves the right to designate the plan options which constitute the basic program of health benefits and to require additional contributions in accordance with the law for any optional coverage elected by an annuitant, retiree, or survivor.

Dental

The State's dental plan, the Quality Care Dental Plan (QCDP), offers a comprehensive range of benefits and is available to all members. The plan is administered by Delta Dental of Illinois. You can find the Dental Schedule of Benefits on the MyBenefits website.

Member Monthly Quality Care Dental Plan (QCDP) Contributions*		
Member Only	**Member Plus 1 Dependent**	**Member Plus 2 or More Dependents**
$11	$17	$19.50

**Part-time employees are required to pay a percentage of the State's portion of the contribution in addition to the member contribution. Special rules apply for non-IRS dependents (see MyBenefits.illinois.gov for more information).*

Life

Basic Life Insurance is provided at no cost to all active members and annuitants. Active employees receive an amount equal to their annual salary. Annuitants under age 60 receive an amount equal to their annual salary on their last day of active employment. Annuitants age 60 or older receive a $5,000 benefit. Member Optional Life coverage is also available to active members and annuitants.

Optional Term Life Rate	
Member by Age	**Monthly Rate Per $1,000**
Under 30	$0.06
30 – 34	$0.08
35 – 44	$0.10
45 – 49	$0.16
50 – 54	$0.24
55 – 59	$0.44
60 – 64	$0.66
65 – 69	$1.28
70 and above	$2.06

Spouse Life Monthly Rate	
Spouse Life $10,000 coverage (Annuitants under age 60 and Employees)	$6
Spouse Life $5,000 coverage (Annuitants age 60 and older)	$3

Child Life Monthly Rate	
Child Life $10,000 coverage	$0.70

AD&D Monthly Rate Per $1,000	
Accidental Death & Dismemberment	$0.02

Vision

Vision coverage is provided at no cost to all members enrolled in a State health plan. All enrolled members and dependents receive the same vision coverage regardless of the health plan selected.

Federally Required Notices

Notice of Creditable Coverage

Prescription Drug information for State of Illinois Medicare-eligible Plan Participants

This Notice confirms that the State Employees Group Insurance Program (SEGIP) has determined that the prescription drug coverage it provides is Creditable Coverage. This means that the prescription coverage offered through SEGIP is on average as good as or better than the standard Medicare prescription drug coverage (Medicare Part D). You can keep your existing group prescription coverage and choose not to enroll in a Medicare Part D plan.

Because your existing coverage is Creditable Coverage, you will not be penalized if you later decide to enroll in a Medicare prescription drug plan. However, you must remember that if you drop your coverage through SEGIP and experience a continuous period of 63 days or longer without creditable coverage, you may be penalized if you enroll in a Medicare Part D plan later. If you choose to drop your SEGIP coverage, the Medicare Special Enrollment Period for enrollment into a Medicare Part D plan is two months after your SEGIP coverage ends.

If you keep your existing group coverage through SEGIP, it is not necessary to join a Medicare prescription drug plan this year. Plan participants who decide to enroll in a Medicare prescription drug plan may need to provide a copy of the Notice of Creditable Coverage to enroll in the Medicare prescription plan without a financial penalty. Participants may obtain a complete Notice of Creditable Coverage at MyBenefits.illinois.gov. Participants may also contact the State of Illinois Medicare Coordination of Benefits Unit at (800) 442-1300 or (217) 782-7007 to obtain a copy or to request a personalized Notice.

Summary of Benefits and Coverage (SBC) and Uniform Glossary

Under the Affordable Care Act, health insurance issuers and group health plans are required to provide you with an easy-to-understand summary about a health plan's benefits and coverage. The regulation is designed to help you better understand and evaluate your health insurance choices.

The forms include a short, plain language Summary of Benefits and Coverage (SBC) and a uniform glossary of terms commonly used in health insurance coverage, such as "deductible" and "copayment."

All insurance companies and group health plans must use the same standard SBC form to help you compare health plans. The SBC form also includes details, called "coverage examples," which are comparison tools that allow you to see what the plan would generally cover in two common medical situations. You have the right to receive the SBC when shopping for, or enrolling in, coverage or if you request a copy from your issuer or group health plan. You may also request a copy of the glossary of terms from your health insurance company or group health plan. All State health plan SBCs, along with the uniform glossary, are available on MyBenefits.illinois.gov.

Notice of Privacy Practices

The Notice of Privacy Practices will be updated on the MyBenefits website, effective July 1, 2017. You have a right to obtain a paper copy of this Notice, even if you originally obtained the Notice electronically. We are required to abide with terms of the Notice currently in effect; however, we may change this Notice. If we materially change this Notice, we will post the revised Notice on our website at MyBenefits.illinois.gov.

MARK YOUR CALENDAR: MAY 1-31, 2017

Benefit Choice Period

State Employees Group Insurance Program

Discover Your Options

Printed on recycled paper

STATE OF ILLINOIS

Department of Central Management
Services, Bureau of Benefits